Behavioral Emergencies

Psychiatric Emergency

- Patient's behavior is disturbing to himself, his family, or his community

Behavioral Change

- Never assume patient has psychiatric illness until all possible physical causes are ruled out

Behavioral Change

- Causes
  - Low blood sugar
  - Hypoxia
  - Inadequate cerebral blood flow
  - Head trauma
  - Drugs, alcohol
  - Excessive heat, cold
  - CNS infections

Behavioral Change

- Clues suggesting physical causes
  - Sudden onset
  - Visual, but not auditory, hallucinations
  - Memory loss, impairment
  - Altered pupil size, symmetry, reactivity
  - Excessive salivation
  - Incontinence
  - Unusual breath odors

Psychiatric Problems

Anxiety

- Most common psychiatric illness (10% of adults)
- Painful uneasiness about impending problems, situations
- Characterized by agitation, restlessness
- Frequently misdiagnosed as other disorders

Anxiety

- Panic attack
  - Intense fear, tension, restlessness
  - Patient overwhelmed, cannot concentrate
  - May also cause anxiety, agitation among family, bystanders

Anxiety

- Panic attack
  - Dizziness
  - Tingling of fingers, area around mouth
  - Carpal-pedal spasms
  - Tremors
  - Shortness of breath
  - Irregular heartbeat
  - Palpitations
  - Diarrhea
  - Sensation of choking, smothering

Phobias

- Closely related to anxiety
- Stimulated by specific things, places, situations
- Signs, symptoms resemble panic attack
- Most common is agoraphobia (fear of open places)

Depression

- Deep feelings of sadness, worthlessness, discouragement
- Factor in 50% of suicides

Depression

Signs, Symptoms

- Sad appearance
- Listless, apathetic behavior
- Crying spells
- Withdrawal
- Pessimism
- Loss of appetite
- Sleeplessness
- Fatigue
- Despondence
- Severe restlessness

Depression

Ask all depressed patients about suicidal thoughts

Asking someone about suicide will NOT "put the idea in their head."

Bipolar Disorder

- Manic-depressive
- Swings from one end of mood spectrum to other
- Manic phase: Inflated self-image, elation, feelings of being very powerful
- Depressed phase: Loss of interest, feelings of worthlessness, suicidal thoughts
- Delusions, hallucinations occur in either phase

Paranoia

- Exaggerated, unwarranted mistrust
- Often elaborate delusions of persecution
- Tend to carry grudges
- Cold, aloof, hypersensitive, defensive, argumentative
- Cannot accept fault
- Excitable, unpredictable

Schizophrenia

- Debilitating distortions of speech, thought
- Bizarre hallucinations
- Social withdrawal
- Lack of emotional expressiveness
- NOT the same as multiple personality disorder

Violence

Suicide

- Suicide attempt = Any willful act designed to end one's own life
- 10th leading cause of death in U.S.
- Second among college students
- Women attempt more often
- Men succeed more often

Suicide

- 50% who succeed attempted previously
- 75% gave clear warning of intent

People who kill themselves, DO talk about it in advance!

Suicide

Take ALL suicidal acts seriously!

Suicide

- Risk factors
  - Men >40 y.o.
  - Single, widowed, or divorced
  - Drug, alcohol abuse history
  - Severe depression
  - Previous attempts, gestures
  - Highly lethal plans

Suicide

- Risk factors
  - Obtaining means of suicide (gun, pills, etc)
  - Previous self-destructive behavior
  - Current diagnosis of serious illness
  - Recent loss of loved one
  - Arrest, imprisonment, loss of job

Violence to Others

- 60 to 70% of behavioral emergency patients become assaultive or violent

Violence to Others

- Causes include
  - Real, perceived mismanagement
  - Psychosis
  - Alcohol, drugs
  - Fear
  - Panic
  - Head injury

Violence to Others

- Warning signs
  - Nervous pacing
  - Shouting
  - Threatening
  - Cursing
  - Throwing objects
  - Clenched teeth and/or fists

Dealing with Behavioral Emergencies

Basic Principles

- We all have limitations
- We all have a right to our feelings
- We have more coping ability than we think
- We all feel some disturbance when injured or involved in an extraordinary event

Basic Principles

- Emotional injury is as real as physical injury
- People who have been through a crisis do not just “get better”
- Cultural differences have special meaning in behavioral emergencies

Techniques

- Speak calmly, reassuringly, directly
- Maintain comfortable distance
- Seek patient's cooperation
- Maintain eye contact
- No quick movements

Techniques

- Respond honestly
- Never threaten, challenge, belittle, argue
- Always tell the truth
- Do NOT “play along” with hallucinations

Techniques

- Involve trusted family, friends
- Be prepared to spend time
- NEVER leave patient alone
- Avoid using restraints if possible
- Do NOT force patient to make decisions

Techniques

- Encourage patient to perform simple, non-competitive tasks
- Disperse crowds that have gathered

Behavioral Emergencies

Assessment

Scene Size-Up

- Pay careful attention to dispatch information for indications of potential violence
- Never enter potentially violent situations without police support
- If personal safety uncertain, stand by for police

Scene Size-Up

- In suicide cases, be alert for hazards
  - Automobile running in closed garage
  - Gas stove pilot lights blown out
  - Electrical devices in water
  - Toxins on or around patient

Scene Size-Up

- Quickly locate patient
- Stay between patient and door
- Scan quickly for dangerous articles
- If patient has weapon, ask him to put it down
- If he won’t, back out and wait for police

Scene Size-Up

- Look for
  - Signs of possible underlying medical problems
  - Methods, means of committing suicide
  - Multiple patients

Initial Assessment

Identification of life-threatening medical or traumatic problems has priority over behavioral problem.

Focused History, Physical Exam

- Be polite, respectful
- Preserve patient's dignity
- Use open-ended questions
- Encourage patient to talk; Show you are listening
- Acknowledge patient's feelings

Assessment: Suicidal Patients

- Injuries, medical conditions related to attempt are primary concern
- Listen carefully
- Accept patient's complaints, feelings
- Do NOT show disgust, horror

Assessment: Suicidal Patients

- Do NOT trust “rapid recoveries”
- Do something tangible for the patient
- Do NOT try to deny that the attempt occurred
- NEVER challenge patient to go ahead, do it

Assessment: Violent Patients

- Find out if patient has threatened/has history of violence, aggression, combativeness
- Assess body language for clues to potential violence
- Listen to clues to violence in patient's speech
- Monitor movements, physical activity
- Be firm, clear
- Be prepared to restrain, but only if necessary

Management

- Your safety comes first
- Trauma, medical problems have priority
- Calm the patient; NEVER leave him alone
- Use restraints as needed to protect yourself, the patient, others
- Transport to facility with appropriate resources

Restraining Patients

- A patient may be restrained if you have good reason to believe he is a danger to:
  - You
  - Himself
  - Other people

Restraining Patients

- Have sufficient manpower
- Have a plan; Know who will do what
- Use only as much force as needed
- When the time comes, act quickly; Take the patient by surprise
- At least four rescuers; One for each extremity

Restraining Patients

- Use humane restraints (soft leather, cloth) on limbs
- Secure patient to stretcher with straps at chest, waist, thighs
- If patient spits, cover face with surgical mask
- Once restraints are applied, NEVER remove them!

Reasonable Force

- Minimum amount of force needed to keep patient from injuring self, others
- Force must NEVER be punitive in nature